

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08361

08358

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lusby</u>				TOWN <u>Lusby</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				1 ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Maple</u> (Middle) (Last) <u>Brown</u>				(Month) (Day) (Year)			
				<u>8</u> , <u>31</u> , 19 <u>57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>C</u>	<u>WIDOWED</u>	<u>Feb 18</u>	<u>41</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House wife</u>				<u>Maryland</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Kelso Buck</u>				<u>Jennie Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Jenne Buck Lusby, ind.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
171X IMMEDIATE CAUSE (A) <u>Co of Cervix</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Carcinoma</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 19 1957</u> to <u>Aug 31 1957</u> , that I last saw the deceased alive on <u>Aug 31 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. W. Ward</u>		M.D.		ADDRESS (Street, city, town, state) <u>5 + Remond</u>		DATE SIGNED <u>9/3/57</u>	
23. (BURIAL) CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>8-3-57</u>		<u>Eastern Chapel</u>		<u>Calvert Co. md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>9-3-57</u>		<u>H. W. Ward</u>		<u>P. Z. Sewell, Prince Fred. ind</u>			

CERTIFICATE OF DEATH

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DATE OF DEATH

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CAUSE OF DEATH

DATE OF DEATH

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BUREAU V. S.

SEP 5 1957

RECEIVED

MASSACHUSETTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08359 CERTIFICATE OF DEATH

08362
 51

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Isaac Edward Cox</u>				4. DATE OF DEATH Month Day Year <u>Aug 1 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28 1871</u>	
9. AGE (In years, last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State of foreign country) <u>Calvert Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Cox</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Tucker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Stanley Cox</u> Address <u>Huntingtown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRIC HEMORRHAGE</u> <u>151X</u> DUE TO (b) <u>Probably Carcinoma of Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROSIS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Page Jett</u> M.D. <u>Perce Pedersen</u> PHYSICIAN'S NAME (Type) <u>PAGE C. JETT MD</u> <u>Perce Pedersen MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Plum Point Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son</u> ADDRESS <u>Mutual, Md.</u>				24a. REC'D BY REGISTRAR <u>8-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>N. W. Ward</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of Registrar	
9. Signature of Physician		10. Signature of Coroner		11. Signature of Medical Examiner		12. Signature of Health Officer	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Funeral Home		16. Signature of Cemetery	
17. Signature of Mortuary		18. Signature of Embalmer		19. Signature of Transporter		20. Signature of Interment	
21. Signature of Burial		22. Signature of Cremation		23. Signature of Disposition		24. Signature of Final Disposition	
25. Signature of Final Disposition		26. Signature of Final Disposition		27. Signature of Final Disposition		28. Signature of Final Disposition	
29. Signature of Final Disposition		30. Signature of Final Disposition		31. Signature of Final Disposition		32. Signature of Final Disposition	
33. Signature of Final Disposition		34. Signature of Final Disposition		35. Signature of Final Disposition		36. Signature of Final Disposition	
37. Signature of Final Disposition		38. Signature of Final Disposition		39. Signature of Final Disposition		40. Signature of Final Disposition	
41. Signature of Final Disposition		42. Signature of Final Disposition		43. Signature of Final Disposition		44. Signature of Final Disposition	
45. Signature of Final Disposition		46. Signature of Final Disposition		47. Signature of Final Disposition		48. Signature of Final Disposition	
49. Signature of Final Disposition		50. Signature of Final Disposition		51. Signature of Final Disposition		52. Signature of Final Disposition	
53. Signature of Final Disposition		54. Signature of Final Disposition		55. Signature of Final Disposition		56. Signature of Final Disposition	
57. Signature of Final Disposition		58. Signature of Final Disposition		59. Signature of Final Disposition		60. Signature of Final Disposition	
61. Signature of Final Disposition		62. Signature of Final Disposition		63. Signature of Final Disposition		64. Signature of Final Disposition	
65. Signature of Final Disposition		66. Signature of Final Disposition		67. Signature of Final Disposition		68. Signature of Final Disposition	
69. Signature of Final Disposition		70. Signature of Final Disposition		71. Signature of Final Disposition		72. Signature of Final Disposition	
73. Signature of Final Disposition		74. Signature of Final Disposition		75. Signature of Final Disposition		76. Signature of Final Disposition	
77. Signature of Final Disposition		78. Signature of Final Disposition		79. Signature of Final Disposition		80. Signature of Final Disposition	
81. Signature of Final Disposition		82. Signature of Final Disposition		83. Signature of Final Disposition		84. Signature of Final Disposition	
85. Signature of Final Disposition		86. Signature of Final Disposition		87. Signature of Final Disposition		88. Signature of Final Disposition	
89. Signature of Final Disposition		90. Signature of Final Disposition		91. Signature of Final Disposition		92. Signature of Final Disposition	
93. Signature of Final Disposition		94. Signature of Final Disposition		95. Signature of Final Disposition		96. Signature of Final Disposition	
97. Signature of Final Disposition		98. Signature of Final Disposition		99. Signature of Final Disposition		100. Signature of Final Disposition	

RECEIVED
JUL 5 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09311

Reg. Dist. No.

51

08360

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Beach</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
3. NAME OF DECEASED (Type or print) <u>Shice</u> First <u>E</u> Middle <u>Wilström</u> Last 4. DATE OF DEATH <u>8</u> Month <u>24</u> Day <u>1957</u> Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash DC</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>J B Sheehy</u>		14. MOTHER'S MAIDEN NAME <u>Eleanna Eklhoff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war & dates of service)		16. SOCIAL SECURITY NO. <u>58250-12121, W</u>	
17. INFORMANT <u>Frank W. C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Crown disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Had several attacks</u> (c) <u>Had several attacks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had several attacks</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY <u>6:30</u> p. m. <u>8/24</u> <u>1957</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>W Beach Cabot Md</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wash Natl Cem -</u>	22d. LOCATION (City, town, or county) (State) <u>Switzland Rd - Pr Geo G. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas M. Idyong</u>		ADDRESS <u>137th N.W. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>8/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>JK W. Ward</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08361

CERTIFICATE OF DEATH

08363

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphia</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Adelphia</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>W.</u> Last <u>Duke</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 14, 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gardner Wadleigh</u>		14. MOTHER'S MAIDEN NAME <u>Jane Carhile</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Conce Kerny</u>		Address <u>Adelphia, Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Hemorrhage</u> causes (a), stating the underlying cause last. (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 years 4 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , to <u>Aug 12</u> , 1957, that I last saw the deceased alive on <u>Aug 12</u> , 1957, and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page Jett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8/13/57</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>		M.D. <u>PRINCE FREDERICK</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Aug. 15, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.A. Wadsworth & Son Funeral, Ind.</u>		ADDRESS <u>18-13-57</u>	
24a. REC'D BY REGISTRAR <u>8-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>H.W. Ward</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Date of registration: _____</p>	
<p>10. Remarks: _____</p>	

BUREAU V. 2

AUG 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08362

Item 8 Film 220 9-13-57 et

CERTIFICATE OF DEATH

08364

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Pittsburg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Albert Feldman				4. DATE OF DEATH August 9 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1904	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Steel Company Pa.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris E. Feldman				14. MOTHER'S MAIDEN NAME Garnet Goldman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT Phyllis Feldman Wife Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/6 , 19 57 , to 8/9 , 19 57 , that I last saw the deceased alive on 8/8 , 19 57 , and that death occurred at 10:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Huntingtown, Md DATE SIGNED 8/9/57							
ACTUAL SIGNATURE Dr. George Weems				M.D. Huntingtown, Md			
PHYSICIAN'S NAME (Type) Dr. George Weems							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Slater Funeral Home		22d. LOCATION (City, town, or county) (State) Pittsburgh, Pa	
23. FUNERAL DIRECTOR'S SIGNATURE A. G. Harkness & Son - Mutual Ind				24a. REC'D BY REGISTRAR H. W. Ward		24b. REGISTRAR'S SIGNATURE H. W. Ward	
DATE 8/9/57				DATE 8/9/57			

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08365/51

Reg. Dist. No.

08363

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Harrison</u> Middle <u>Lerner</u> Last				4. DATE OF DEATH <u>Aug</u> Month <u>3</u> Day <u>1957</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>9-8</u>		9. AGE (In years last birthday) <u>67</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manuland</u>		11. BIRTHPLACE (State or foreign country) <u>Manuland</u>			
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>James Garner</u>					
14. MOTHER'S MAIDEN NAME <u>Barbara Rich</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]					
16. SOCIAL SECURITY NO. <u>217-05-3848</u>		17. INFORMANT <u>Sda M. Garner, husb., md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4:0.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u> NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4 Aug 57</u>			
22a. (BURIAL) CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St John</u>			
22d. LOCATION (City, town, or county) (State) <u>Prinsep</u> <u>md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u> <u>Prince Frederick</u> ADDRESS					
24a. REC'D BY REGISTRAR <u>8-5-57</u> DATE		24b. REGISTRAR'S SIGNATURE <u>N.W. Ward</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

1957

1957

1957

08364

CERTIFICATE OF DEATH

08366

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabnet</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Cabnet</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelina</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelina</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>LENORA</u> Middle <u>B.</u> Last <u>MORSELL</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1878</u>
9. AGE (In years, last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <u>5</u> Days <u>15</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cabnet Co., Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cephas H. Bowen</u>		14. MOTHER'S MAIDEN NAME <u>Sally Skinner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-42</u>	
17. INFORMANT <u>John B. Morsell - Adelina, Ind.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>464X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Popliteal Phlebitis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 12, 1957</u> to <u>Aug. 10, 1957</u> , that I last saw the deceased alive on <u>August 10, 1957</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>—</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C. J. 77</u>		ADDRESS (Street, city or town, state) <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 13, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Princeton, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Hackbusch & Son - Mutual, Ind.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	
DATE <u>8-12-57</u>			

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

C8365

CERTIFICATE OF DEATH

08367

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Wesley</u> (Middle) <u>S.</u> (Last) <u>Parson</u>				(Month) <u>8</u> (Day) <u>1</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE/MARRIED/ WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb 12</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James J. Parson</u>				14. MOTHER'S MAIDEN NAME <u>Christina Ray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>916-12-5391A</u>		17. INFORMANT & ADDRESS <u>Mildred Parson, Huntington Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
151X IMMEDIATE CAUSE (A) <u>Carcinoma of stomach</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-1</u> , 19 <u>57</u> , to <u>8/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/1</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>W. Weems</u>		ADDRESS (Street, city, town, state) <u>M.D. Huntington, Md</u>		DATE SIGNED <u>8/3/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>8-4-57</u>		NAME OF CEMETERY OR CREMATORY <u>St Edmunds</u>		LOCATION (City, town, or county) (State) <u>Calvert Md</u>	
24. REC'D BY REGISTRAR DATE <u>8-4-57</u>		REGISTRAR'S SIGNATURE <u>N.W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell, Jr. Frederick Md</u>			

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DEATH CERTIFICATE

BUREAU V. S.

AUG 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 File # 220 9-11-57 et

CERTIFICATE OF DEATH

08368

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY Calvert				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 39				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Anne Arundel				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) "Rosehaven" North Beach				d. STREET ADDRESS 02x2.2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Middle Last Susan A. Saunders				4. DATE OF DEATH Month Day Year 8 31 1957				5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 1/4/77				9. AGE (In years last birthday) 80 yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Homemaker, retired)				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Joseph Harding				14. MOTHER'S MAIDEN NAME Amelia Graves				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Joseph Saunders, N. Beaulieu				Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular cerebral disease (c) Fractured Hip				INTERVAL BETWEEN ONSET AND DEATH 6 wks				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell and fractured hip and dislocated shoulder				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was walking across floor and fell				20c. TIME OF INJURY Hour o. m. p. m. 1130 July 23 1957				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) N. Beaulieu				(County) AA				(State) MD			
21. I certify that I attended the deceased from 7/23 , 19 57 , to 8/31 , 19 57 , that I last saw the deceased alive on 8/31 , 19 57 , and that death occurred at 12:50 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 4 W Ward Owings, Maryland				DATE SIGNED Dr. Hugh W. Ward				22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 9/3/57				22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery				22d. LOCATION (City, town, or county) Washington, D. C.				(State)																			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Maryland				24a. REC'D BY REGISTRAR EP 3				24b. REGISTRAR'S SIGNATURE 1957				24c. REGISTRAR'S SIGNATURE Hugh W. Ward				24d. REGISTRAR'S SIGNATURE																											

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 8

SEP 3 1957

RECEIVED